TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MAJORS MEDICAL SERVICE

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-17-2270-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 27, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Amount in Dispute: $650.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "For each date of service from 9/16/15 through 3/14/16 the requestor billed a total of $81.29. The cumulative total billed for dates 9/16/15 through 3/14/16 is $569.03. Thus, preauthorization was required for dates of service 5/16/16 and 6/16/16. Texas Mutual has no record of receiving such request from the requestor and the requestor presented no evidence with its DWC060 packet it requested preauthorization. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 16, 2015 through June 16, 2016	Durable Medical Equipment (DME) Rentals	$650.32	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - CAC 197 – Precertification/authorization/notification absent
    - 785 – Service rendered is integral to service requiring preauthorization. Preauthorization not sought/approval not obtained for that service

Issues

1. Is the requestor seeking reimbursement for disputed dates of service June 16, 2015, July 16, 2015, August 16, 2015, November 16, 2015 and December 16, 2015?
2. Did the requestor waive the right to medical fee dispute resolution for dates of service September 16, 2015, October 16, 2015, January 16, 2016, February 16, 2016 and March 16, 2016?
3. Did the requestor submit a medical bill and EOBs for disputed date of service, April 16, 2016?
4. Was the requestor required to obtain preauthorization for DME rendered on May 16, 2016 and June 16, 2016?

Findings

1. The requestor identified disputed dates of service, June 16, 2015, July 16, 2015, August 16, 2015, November 16, 2015 and December 16, 2015 on the "*Table of Disputed Services"*, however the sought amount identified for each date of service is $0.00 and under the *"Amount Paid"* column of the same table the requestor identified that payments were issued by the insurance carrier. As a result, the Division will not consider these disputed dates of service in this review, as the requestor identified these services as paid by the insurance carrier.

   The Division will however, review the remaining disputed services identified on the "*Table of Disputed Services"* as not paid in this review.

2. The requestor seeks reimbursement for disputed dates of service September 16, 2015, October 16, 2015, January 16, 2016, February 16, 2016, March 16, 2016, April 16, 2016, May 16, 2016 and June 16, 2016.

   28 Texas Administrative Code §133.307(c) (1) states:
   Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.
   (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   The dates of the services in dispute are September 16, 2015, October 16, 2015, January 16, 2016, February 16, 2016 and March 16, 2016. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on March 27, 2017. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c) (1) (B). The Division concludes that the requestor has failed to timely file dates of service September 16, 2015, October 16, 2015, January 16, 2016, February 16, 2016 and March 16, 2016 with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for these dates of service.

   Disputed dates of service, April 16, 2016, May 16, 2016 and June 16, 2016 were submitted timely and are eligible for review. As a result, the Division will review these dates of service according to the applicable rules and guidelines.

3. The requestor seeks reimbursement for HCPCS Codes K0195 and K0001 rendered on April 16, 2016. Review of the DWC060 packet does not contain copies of EOBS and CMS-1500's for this disputed date of service.

   28 Texas Administrative Code §133.307(c) (2) (J-K) states in pertinent part, "(c) Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division... (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include...(J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions); (K) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB..."

   The Division finds that the requestor submitted insufficient documentation to support that the insurance carrier had an opportunity to review and audit the disputed charges rendered on April 16, 2016. As a result, the Division finds that this date of service is not eligible for review due to the insufficient documentation submitted for this dates of service. As a result, $0.00 is recommended for HCPCS Codes K0001 and K0195.

4. The requestor billed for HCPCS Codes K0195 and K0001 rendered on May 16, 2016 and June 16, 2016. Review of the EOBs submitted by the requestor for dates of service May 16, 2016 and June 16, 2016 indicates that the insurance carrier denied HCPCS Codes K001 and K0195 with denial/reduction codes:

    - CAC 197 – Precertification/authorization/notification absent
    - 785 – Service rendered is integral to service requiring preauthorization. Preauthorization not sought/approval not obtained for that service

    28 Texas Administrative Code §134.600 states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes... (9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental)...."

    Review of the submitted documentation supports that requestor billed for DME equipment in excess of $500.00 cumulative rental. As a result, the disputed services required preauthorization. The documentation submitted by the requestor does not support that preauthorization was obtained as required by 28 Texas Administrative Code 134.600. As a result, reimbursement cannot be recommended for HCPCS Codes K0195 and K0001 rendered on May 16, 2016 and June 16, 2016. The requestor is therefore entitled to $0.00 reimbursement for the disputed charges.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. This finding is based upon a review of all the evidence presented by the parties in this dispute. Even though not all the evidence was discussed, it was considered. For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		May 5, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.